BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:	)	
Harold S. Budhram, M.D.	)	**Case No. 02-2013-235538**
Physician's and Surgeon's Certificate No. G 31973	)	
Respondent	)	

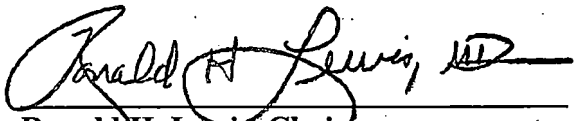
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 10, 2018.

IT IS SO ORDERED: September 10, 2018.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, Chair
Panel A

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **HAROLD S. BUDHRAM, M.D.** **5145 Shasta Dam Blvd.** **Shasta Lake, CA 96019** **Physician's and Surgeon's Certificate No. G 31973** Respondent.	Case No. 02-2013-235538 OAH No. 2017031050 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Mara Faust, Deputy Attorney General.

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2. Respondent Harold S. Budhram, M.D. (Respondent) is represented in this proceeding by attorney Nicole D. Hendrickson, Esq., whose address is: 655 University Avenue, Suite 119 Sacramento, CA 95825

3. On or about July 1, 1976, the Board issued Physician's and Surgeon's Certificate No. G 31973 to Harold S. Budhram, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in the Second Amended Accusation No. 02-2013-235538, and will expire on July 31, 2020, unless renewed.

JURISDICTION

4. Second Amended Accusation No. 02-2013-235538 was filed before the Board, and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent on April 18, 2018. Respondent timely filed his Notice of Defense contesting the Second Amended Accusation.

5. A copy of the Second Amended Accusation No. 02-2013-235538 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the Second Amended Accusation No. 02-2013-235538. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in the Second Amended Accusation No. 02-2013-235538, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Second Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a *prima facie* case with respect to the charges in the Second Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 02-2013-235538 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's Disciplinary Order as set forth below.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 31973 issued to Respondent Harold S. Budhram, M.D. is revoked. However, such order of revocation is stayed and Respondent is placed on five (5) years of probation upon the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s) II through V of the Act, excluding Fentanyl and Dilaudid, which are both Schedule II controlled substances.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or

cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at

correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. PRESCRIBING PRACTICES COURSE. Within 30 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of

the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

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Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

7. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

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If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

8. MONITORING - PRACTICE/BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

9. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

10. MAINTAINING CURRENT WRITTEN PROTOCOLS AND PROCEDURES FOR PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, every year, Respondent must provide to the Board or their agent a current copy of protocols and procedures for any Physician Assistant and/or Furnishing Nurse Practitioner that Respondent currently employs.

11. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

12. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

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Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice. Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

15. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct

patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

16. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke

probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Nicole D. Hendrickson, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 7-16-18

HAROLD S. BUDHRAM, M.D.
Respondent

I have read and fully discussed with Respondent Harold S. Budhram, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 7-16-2018 Nicole Hendrickson
NICOLE D. HENDRICKSON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: July 16, 2018

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

Mara Faust

MARA FAUST
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 02-2013-235538

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **HAROLD S. BUDHRAM, M.D.** 5145 Shasta Dam Blvd. Shasta Lake, CA 96019 Physician's and Surgeon's License No. G 31973, Respondent.	Case No. 02-2013-235538 [Consolidated to include 800-2013-000974] **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Second Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 1, 1976, the Medical Board issued Physician's and Surgeon's License No. G 31973 to Harold S. Budhram, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges herein and will expire on July 31, 2018, unless renewed.

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3. Accusation No. 800-2013-000974 was filed and served on Respondent on September 15, 2016, and the five causes for discipline in that accusation are included in this pleading as the seventh through eleventh causes for discipline. Accusation No. 02-2013-235538 was filed and served on Respondent on September 19, 2016, and six of the eight causes for discipline in that accusation are included in this pleading as the first through sixth causes for discipline.

4. The First Amended Accusation was filed and served on Respondent on December 16, 2016, which consolidated Accusation No. 800-2013-000974 into Accusation No. 02-2013-235538 and added a fourteenth cause for discipline, now the twelfth cause for discipline in this pleading.

JURISDICTION

5. This Second Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

6. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

7. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

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"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 2725 (b) and (c) of the Code states in relevant part that "(b)The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:"

"(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene and protection of patients: and the performance of disease prevention and restorative measures."

"(2) Direct or indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by section 1316.5 of the Health and Safety Code."

"..."

"(4) Observation of signs and symptoms of illness, reaction to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or

standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures."

"(c) 'Standardized procedures,' as used in this section, means either of the following:"

"(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

"(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code."

"The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing."

10. Section 3502[1] of the Code states:

"(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

"(b)(1) Notwithstanding any other provision of law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant

[1] Business and Professions Code section 3502 was amended by Stats. 2015, Ch. 536, Sec. 2. Effective January 1, 2016.

to this subdivision shall do so only according to patient specific orders from the supervising physician and surgeon.

"(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when that assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

"(c)

(1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

"(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

"(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow up care.

"(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

"(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

"(2)(A)(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

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"(B) In complying with subparagraph (A), The supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

"(3) Notwithstanding any other provision of law, the Medical Board of California or board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

"(d) No medical services may be performed under this chapter in any of the following areas:

"(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

"(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

"(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

"(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

"(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501."

11. Section 3502.1 of the Code states:

"(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

"(b) "Drug order" for purposes of this section, means an order for medication which is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to 'prescription' in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

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"(2) A physician assistant may not administer, provide or issue a drug order for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with the provisions of Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number,

and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e)(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed and countersigned, and dated by a supervising physician and surgeon within seven days.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

"(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

California Code of Regulations, title 16, section 1399.54 states:

"(a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

"(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

"(c) The board or Medical Board of California or their representative may require proof or demonstration of competence from any physician assistant for any tasks, procedures or management he or she is performing.

"(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician."

12. California Code of Regulations, title 16, section 1399.545, states:

"(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

"(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

"(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

"(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

"(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

"(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

"(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

"(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient.

For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

"(4) Other mechanisms approved in advance by the board.

"(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision."

13. Title 16 California Code of Regulations (hereinafter "CCR") section 1379 provides that "A physician and surgeon or a podiatrist who collaborates in the development of standardized procedures for registered nurses shall comply with Title 16 CCR sections 1470 through 1474 governing development and use of standardized procedures."

14. Title 16 CCR section 1474 provides the following:

"Following are the standardized procedure guidelines jointly promulgated by the Medical Board of California and by the Board of Registered Nursing:"

"(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof."

"(b) Each standardized procedure shall:

(1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it.

(2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.

(3) State any specific requirements which are to be followed by registered nurses in performing particularized procedure functions.

(4) Specify any experience, training, and/or education requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

(7) Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

(9) State the limitations on settings, if any, in which standardized procedure functions may be performed.

(10) Specify patient record keeping requirements.

(11) Provide for a method of periodic review of the standardized procedures."

DRUGS

15. This First Amended Accusation concerns controlled substances prescribed to various patients by Respondent, as more fully described below:

16. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long term chronic pain. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent that morphine and hundreds of more times potent than heroin.[2] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(c). It is a dangerous drug pursuant to California Business and Professions Code section 4022

[2] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

17. Oxycodone –The generic name for the drug OxyContin. Oxycodone is a long acting opioid analgesic used to treat moderate to severe pain. It has a high danger of abuse and can lead to addiction. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

18. Oxycodone with Acetaminophen – The generic name for Percocet. Percocet is a short acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

19. Morphine Sulfate – The generic name for the drug MScontin or Kadian. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Methadone Hydrochloride – The generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Hydrocodone with acetaminophen – The generic name for the drugs Vicodin, Norco, Lorcet and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of

Federal Regulations Title 21 section 1308.13(e).[3] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

22. Zolpidem Tartrate – The generic name for Ambien. Zolpidem Tartrate is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem Tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. Lorazepam – The generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

24. Clonazepam – The generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

25. Testosterone – The generic name for Androderm. Testosterone is a steroid hormone and a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f)(30), and a dangerous drug pursuant to Business and Professions Code section 4022.

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[3] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

26. Seroquel – The brand name for the drug quetiapine fumarate, an antipsychotic medication classified as a dangerous drug as defined by California and Professions Code section 4022.

27. Alprazolam – The generic name for the drug Xanax. Alprazolam is classified as a benzodiazepine indicated for the treatment of anxiety disorders. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) (2), and Health and Safety Code section 11057(d). It is a dangerous drug as defined by California Business and Professions Code section 4022.

28. Tylenol with Codeine- is an opioid medication classified as a Schedule III controlled substance pursuant to California Health and Safety Code section 11056(e)(2) and a dangerous drug as defined by California Business and professions Code section 4022.

29. Ultram- The brand name for tramadol, a pain killer. Ultram is classified as a Schedule IV Controlled Substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (b) and Health and Safety Code section 11057 subdivision (c). It is a dangerous drug as defined by California Business and Professions Code section 4022.

30. Prozac, the brand name for fluoxetine, and is classified as an antidepressant. Prozac is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d) and a dangerous drug as defined by California Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence - Opioid Prescribing-Patient W.W.)

31. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient W.W. The circumstances are as follows:

32. Respondent had been treating patient W.W., a 54-year-old male, since at least July, 2009, for chronic lower back strain, COPD, and notes a history of migraines. The notes are difficult to read due to poor penmanship. The patient is status post lumbar fusion and is referred to a pain specialist for epidural injections. However, Respondent makes no follow-up on this referral. In or about August 2009, Respondent was treating the patient's pain with Percocet

10/325 mg #180 on a monthly basis. However, in or about October 2009, Respondent prescribed Norco 10/325 mg, #90 and prescribed this medication, on a monthly basis, through December 2010, to the patient. The notes lack justification for all these changes. On January 3, 2010, Respondent added the prescription of OxyContin 60 mg #60, monthly, and continued prescribing this medication through July 12, 2013. On or about February 24, 2011, Respondent prescribed Methadone Hydrochloride 10 mg, #120 monthly through at least May 3, 2016, to patient W.W. without justification. On or about September 6, 2013, Respondent prescribed to the patient, Morphine Sulfate, 10mg, #60, monthly, through at least May 3, 2016, and without justification.

33. In or about May, 2010, Respondent documents that W.W. is a diabetic but no labs are referenced. Review of the labs shows that the patient's glucose was 121 a month earlier. Glucophage is started. A month later, after this diagnosis is made, Respondent's note does not reference diabetes or how the patient is doing on Glucophage but only discusses his back pain. In or about October 2012, the patient's Hgba1c was 7.9. Three days later, Respondent sees this patient and does not address the patient's blood sugar level. Respondent does not address the patient's diabetes again in the notes until September 2015, when the patient's Hgba1c is over 13.

34. In or about December 2010, patient W.W. describes sexual symptoms and Erectile Dysfunction (ED) is diagnosed and depo-testosterone is prescribed. The lab reviews shows that testosterone is low in the patient on several occasions from 2011 through 2015.

35. Patient has MRIs in 2012, 2014 and 2016 showing degenerative lumbar disease. There were urine toxicology screens on July 29, 2010, April 25, 2012, March 9, 2016, June 20, 2016, all with consistent results. No pain contract was noted in the patient's medical records.

36. Respondent's care and treatment of W.W. regarding opioid prescribing was grossly negligent in the following respects:

a. Respondent did not justify his use of two simultaneous short-acting opioids, Norco and Percocet, for patient W.W. The patient had documented reasons for pain, yet Respondent failed to justify opioid changes.

b. Respondent prescribed two long acting opioids, methadone and OxyContin, together and did not choose the lowest doses. Respondent failed to do any equinalgesic

dosing before arriving at the doses he chose. Respondent failed to justify the continued prescribing of these medications.

c. Respondent prescribed high dose opioids to this patient and never attempted to wean the patient off the medications.

d. Respondent failed to conduct an assessment of the patient's addiction risk and failed to warn the patient about the risks of addiction though he was prescribing high dose narcotic therapy for the patient's chronic pain over many years.

37. Respondent's conduct as described above is collectively an extreme departure from the standard of care in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's Physician's and Surgeon's certificate.

SECOND CAUSE FOR DISCIPLINE
(Gross Negligence - Diabetes Treatment-Patient W.W.)

38. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient W.W. The circumstances are as follows:

39. Complainant re-alleges paragraphs 31 through 37.

40. Respondent failed to adequately manage W.W.'s diabetes on repeated visits despite seeing the patient monthly for pain medication refills and such failures collectively constitute an extreme departure from the standard of care in violation of section 2234(b) of the code.

THIRD CAUSE FOR DISCIPLINE
(Gross Negligence-Opioid Prescribing-Patient D.R.)

41. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient D.R. The circumstances are as follows:

42. Respondent began treating patient D.R., a 46-year-old-male, since the fall of 2011, for chronic neck pain and knee pain, COPD and chemical burns to abdomen, arms and legs which was caused by an on the job injury. Patient D.R. was and is disabled and received worker's compensation. Initially, Respondent prescribed Norco 10/325 mg, #180 to the patient. From on

or about November 3, 2011,[4] through May 31, 2012, Respondent prescribed Norco 10/325 mg, #180, monthly to the patient. From on or about June 5, 2012, through April 29, 2016, the monthly dose of Norco was reduced to #90. However, from on or about June 5, 2012, (when the Norco was cut in half by Respondent), Respondent prescribed Percocet 10/325 mg, #90, monthly to the patient through February 1, 2013. On or about April 9, 2013, Respondent prescribed Kadian (morphine) 30 mg #60 to the patient. Thereafter, from on or about June 6, 2013, through September 4, 2014, Respondent prescribed Oxycodone Hydrochloride 30 mg, #60 per month through September 4, 2014, to patient D.R. without a rationale for the change. Finally, from on or about October 3, 2014, through at least April 29, 2016, Respondent prescribed morphine 15 mg, #60, monthly to the patient. Along with the above-referenced opioids, Respondent also prescribed lorazepam, 1mg, #100, from on or about January 17, 2012, through July 5, 2012, and January 21, 2016, through February 29, 2016, to the patient.

43. In or about December 2013, D.R. reports a decreased sex drive and erectile dysfunction and D.R has been on chronic narcotics (a risk factor for low testosterone). Respondent prescribed Androgel[5] that day (filled December 3, 2013) but does not document a diagnosis for the prescription and does not document in the medical record that he prescribed it.

44. Urine tests for medications that are prescribed was consistent on or about October 1, 2014, but inconsistent on or about February 26, 2016, for alcohol, hydrocodone (unexpected positive) and oxycodone (unexpected negative).

45. Respondent's care and treatment of D.R. was grossly negligent in the following respects:

a. The patient's chart is missing medical records.

b. Respondent prescribed two short-acing opioids which over a period of time which were not justified in the medical record. In addition, Respondent failed to document a rationale for when doses or medications changed.

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[4] Respondent recorded prescription for December 7, 2011, even though patient filled the prescription on November 3, 2011.

[5] Androgel is merely another name for Testosterone gel.

c. Respondent conducted two drug screens and the results of the February 26, 2016, drug screen was inconsistent with what Respondent prescribed, but he failed to discuss this drug screen result with the patient.

d. Respondent failed to document the reasons for prescribing sedative medication in conjunction with chronic narcotic therapy.

46. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's Physician's and Surgeon's Certificate.

FOURTH CAUSE FOR DISCIPLINE
(Gross Negligence-Opioid Prescribing-Patient R.M.)

47. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient R.M. The circumstances are as follows:

48. Respondent had been treating patient R.M., a 71-year-old man, since at least on or about January 6, 2008, for chronic hip and back pain for documented lumbar disc disease and degenerative joint disease of the right hip. He was prescribing Norco 10/325 mg, #90 monthly from on or about January 15, 2010, through April 2, 2016, to the patient. In addition, Respondent prescribed OxyContin 40 mg. #90 from on or about January 6, 2008, though December 16, 2010, then changed the prescription to oxycodone 30 mg, #90 on or about January 19, 2011, and then increased the dose to #120 Oxycodone 30 mg monthly to the patient from on or about February 17, 2011, through March 16, 2015. There is no justification for this large amount of medication in the notes, in either the history and physical, or the plan in the record.

49. In September 2011, patient R.M. tells Respondent that he wants to be weaned off Norco and would like Ambien. However, CURES indicates that the patient received Norco from four other providers in 2011, receiving #240 Norco in 18 days. In 2012, there were eleven more novel prescribers of hydrocodone. In 2013, there were five new prescribers of hydrocodone. In 2014, there were four more providers giving the patient hydrocodone. In 2015, there were five

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new prescribers of hydrocodone. The prescriptions were filled by the patient at multiple pharmacies and yet Respondent seems unaware of the extra doses of this medication.

50. Along with the above-referenced opioids, Respondent also prescribed Ambien 10 mg. #15 from on or about December 31, 2011, through January 28, 2012, to the patient. He also prescribed lorazepam, 1mg, #30, monthly from on or about January 30, 2012, through February 4, 2016, to the patient.

51. Patient R.M. reported to Respondent on or about September 28, 2011, that on September 11, 2012, he had his medication stolen from his truck. On or about July 17, 2013, patient R.M. was hospitalized at Mercy Hospital and appeared confused, admitted drinking alcohol and was observed going through Norco withdrawal. On or about December 8, 2013, patient went to Mercy Hospital with a concussion and a scalp abrasion, where he claimed he was jumped by five men who robbed him of his Norco. Patient was admitted to Mercy Hospital on or about May 18, 2014, where he initially denied alcohol use and then admitted drinking two drinks a day. The Mercy Hospital records of May 18 through May 20, 2014, lists the patient's past history as chronic pain with continued narcotic habituation. All of the above Mercy Hospital records were in Respondent's chart of patient R.M. A toxicology screen performed on February 10, 2012, for opioids had an unexpected negative.

52. Respondent's care and treatment of R.M. was grossly negligent in the following respects:

a. Respondent prescribed high dose short-acting opioid (Norco) along with a high dose long-acting opioid (OxyContin/oxycodone) over a long period of time which was not justified in the medical record. In addition, Respondent failed to document a rationale for when doses or medications changed.

b. Respondent failed to conduct an assessment of the patient's addiction risk even though he was prescribing narcotic therapy for his chronic pain.

c. Respondent conducted one drug screen and the results showed the patient was not likely using a narcotic mediation prescribed by Respondent, but he failed to discuss this drug screen result with the patient.

d. Respondent failed to obtain a thorough history of the patient's substance abuse problem, and failed to consult and consider collateral sources and address the other red flags of addiction that arose from Mercy Hospital records.

e. Respondent failed to document the reasons for prescribing sedative medication in conjunction with chronic narcotic therapy.

53. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's Physician's and Surgeon's certificate.

FIFTH CAUSE FOR DISCIPLINE
(Gross Negligence - Opioid Prescribing-L.M.)

54. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient L.M. The circumstances are as follows:

55. Respondent had been treating patient L.M., a 48-year-old woman, since at least on or about January 29, 2009, for chronic lumbar strain and COPD. The notes are handwritten and hard to read. He was prescribing Norco 10/325 mg #90, Kadian/Morphine 30 mg, #60 and Klonopin 1mg, # 120 to the patient monthly at that time. From on or about January 8, 2010, through May 6, 2016, Respondent continued to prescribe these three medication monthly. The morphine that Respondent prescribed remained stable at #60 per month for the entire period of January, 2016, through May, 2016, as did the Klonopin at #120 per month. However, the amount of Norco Respondent prescribed to this patient shifted from #120 per month in 2010 through 2011, to #180 per month in 2012 through 2014 and back to #120 per 2015 through April, 2016. There was a short period of time from on or about October 18, 2014, through February 12, 2015, when Respondent prescribed oxycodone 20 mg, #120 instead of the Norco to this patient. Nevertheless, the patient continues to refill her Norco prescription from September through November 2014, after she was supposed to be switched off oxycodone, which she also filled in October and November 2014. The medical records fail to explain why these medications are needed and are not justified by the diagnosis of either lumbar strain or epilepsy.

56. The March 27, 2009 note indicates that the patient's medicines were stolen. In 2010, the patient receives prescriptions of Norco from two other providers. Inconsistent toxicology screen occurred on three occasions for this patient as follows: December 17, 2015, there was an unexpected negative for clonazepam, on April 14, 2016, there was an unexpected negative for clonazepam and on July 7, 2016, there was an unexpected positive for methamphetamine and amphetamines. Respondent does not deal with these inconsistent results in his records.

57. Respondent's care and treatment of L.M. was grossly negligent in the following respects:

a. Respondent prescribed a high dose short-acting opioid (Norco) along with a high dose long-acting opioid (Kadian/morphine) over a period of time which was not justified in the medical record. In addition, Respondent failed to document a rationale for when doses or medications changed.

b. Respondent treated the patient's pain solely with prescription medications. He did not consider treatments such as physical therapy or stress reduction.

c. Respondent failed to conduct an assessment of the patient's addiction risk even though he was prescribing narcotic therapy for his chronic pain.

d. Respondent conducted three drug screens and the results showed the patient was likely using a narcotic medication not prescribed by Respondent, and not using medications Respondent prescribed, but he failed to discuss this drug screen result with the patient or address the issue at all.

e. Respondent failed to obtain a thorough history of the patient's substance abuse problem, failed to consult, consider collateral sources and address the other red flags of addiction such as stolen medication, and receiving medication from multiple providers.

f. Respondent failed to document the reasons for prescribing sedative medication in conjunction with chronic narcotic therapy.

58. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's Physician's and Surgeon's certificate.

SIXTH CAUSE FOR DISCIPLINE
(Gross Negligence - Opioid Prescribing-B.M.)

59. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient B.M. The circumstances are as follows:

60. Respondent had been treating patient B.M., a 60-year-old woman, since on or about January 10, 2011, for chronic back pain, fibromyalgia, asthma, shoulder pain and prior surgery on her knees. He was prescribing the patient Ambien 10 mg, #60 and Ativan 2 mg, #60 monthly from on or about January 10, 2011, through February 17, 2016, to the patient. Respondent prescribed a Fentanyl Transdermal System 50 mch/1 hr, #15, on or about March 16, 2011, through February 21, 2012, approximately every two months and from April 19, 2012, through August 20, 2012, monthly, to the patient. Respondent continued to prescribe to B.M. Fentanyl patches, 50 mch/1hr, #15, every other month from on or about October 3, 2012, through February 26, 2014, when the prescriptions again became monthly through July 3, 2014. From on or about October 1, 2014, through June 3, 2015, the patient again received Fentanyl patch prescriptions from Respondent every other month, and then monthly through October 14, 2015. In addition, Respondent prescribed Norco 10/325 mg #100 on or about March 1, 2011, then #50 Norco on March 18, 2011, and March 29, 2011, and then #90 Norco monthly from on or about April 4, 2011, through October 12, 2015, to the patient. None of these changes in dosage are explained by Respondent. Lastly, Respondent prescribed Percocet 10/325 mg, #90 on or about October 26, 2015, to the patient.

61. In January 2013, patient B.M. says she spilled her Ativan down the drain. Respondent does not document how he deals with that fact. A toxicology screen on or about September 28, 2015, has inconsistent results for Norco and Ambien. On or about October 25, 2015, Respondent stops prescribing Norco and fentanyl but does not explain why care is taken over by another doctor on or about December 31, 2015.

62. Respondent's care and treatment of B.M. was grossly negligent in the following respects:

a. Respondent prescribed a high dose short-acting opioid (Norco) along with a high dose long-acting opioid (fentanyl) over a period of time which was not justified in the medical record. In addition, Respondent failed to document a rationale for when doses or medications changed.

b. Respondent diagnosed the patient's painful back condition based only on the patient's reported history. He did not consult with other physicians who had treated the patient relating to back pain. Respondent made no radiologic investigation of the back pain. Respondent failed to determine a more precise etiology of the patient's back pain.

c. Respondent failed to conduct an assessment of the patient's addiction risk even though he was prescribing narcotic therapy for her chronic pain.

d. Respondent failed to obtain a thorough history of the patient's substance abuse problem, failed to consult and consider collateral sources, and failed to address other red flag warning signs such as shopping for other providers and spilling her medication down the drain.

e. Respondent failed to document the reasons for prescribing sedative medication in conjunction with chronic narcotic therapy.

63. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's Physician's and Surgeon's certificate.

SEVENTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts-Patient S.M.)

64. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(c) of the code in that he was repeatedly negligent in his care of patient S.M. The circumstances are as follows.

65. In or about 1994, Respondent undertook the care and treatment of patient S.M., then a 46-year-old male. This patient had a history of hypertension, head injury in 2006, chronic obstructive pulmonary disease (COPD), cervical disc disease, chronic anxiety, depression, insomnia and an undefined psychiatric disorder, (probably Bipolar I or Schizoaffective Disorder).

The patient reported a habit of smoking tobacco and marijuana and had a prior history of alcoholism and reported heroin use.

66. Respondent prescribed the patient benzodiazepines; alprazolam (brand name Xanax) and lorazepam (brand name Ativan) from 1999 through 2015 for anxiety. He also prescribed Seroquel to the patient for insomnia. During the period of Respondent's care, the patient was hospitalized in a psychiatric hospital in 2010 for a manic episode and was arrested in 2012 for assaulting his family, resulting in a subsequent finding of incompetence, and was hospitalized in a psychiatric facility for nine months. In 2013 the patient was in jail.

67. On or about September 20, 2013, patient's step-daughter filed a complaint with the Board expressing concern about Respondent's excessive prescribing of Xanax to S.M., as well as his improper management of S.M.'s psychiatric issues. The complainant was concerned that when S.M. was discharged from a psychiatric hospital with prescribed psychiatric medication, Respondent would then change the medications. Thereafter, the complainant noticed that S.M. would again have recurrent psychiatric symptoms such as paranoia, delusions and hallucinations. The complainant reported that she and other family members made multiple phone calls to Respondent's office expressing concern about his care and treatment of S.M. but Respondent never returned the calls. Respondent never documented these calls in S.M.'s medical records.

68. The medical records reveal that on August 24, 2010, the patient was seen by Respondent after his psychiatric hospitalization. The medical notes from Respondent indicate that this patient was in a "mental hospital for anxiety and anger...not suicidal...He is now on many psychiatric medications, sleeps a lot during the day." Respondent's diagnosis was "Anger, schizophrenia" and he prescribed two months of Xanax 1 mg, #180, with advice for the patient to decrease his Haldol[6] to two a day.

69. On September 24, 2010, Respondent again saw patient S.M. who reported that he wanted to quit Haldol and Cogentin. The reference to Cogentin is almost illegible. The chart note reports decreased affect and diagnosis of "Schiz," which is difficult to read. Respondent

[6] Haldol-The brand name for Haloperidol, is an antipsychotic medication that is a dangerous drug pursuant to Bus. and Prof. Code section 4022.-

prescribed Seroquel 100 mg, #90 and Xanax 1 mg, #180, and advised the patient to decrease Haldol and Cogentin. The next visit on October 12, 2010, the patient reported more anxiety, stress, difficulty sleeping and decreased energy as well as constipation. Respondent diagnosed patient S.M. with anxiety and gave the patient samples of Seroquel.

70. Following the visits from 2010 through 2012, Respondent typically prescribed benzodiazepines in three month quantities (i.e. usually #180 Xanax or Ativan) for anxiety and stress, and from 2013 through 2014 he prescribed Ativan 1 mg in monthly quantities (i.e. usually #60). In 2015, Respondent was prescribing #30 Ativan 1 mg a month to the patient for anxiety and stress. Three toxicology tests were performed on this patient with regards to lorazepam: January 15, 2015 (positive for lorazepam); December 21, 2015 (negative for lorazepam); and March 21, 2016 (negative for lorazepam), yet Respondent took no action on these results and claimed to be unaware of them.

70. Respondent failed to recognize the risks involved in prescribing benzodiazepines for long periods of time, especially in large quantities. Respondent made no effort until 2015 to ensure patient S.M. was not using other illicit substances via drug screening, nor asked the patient about his use of alcohol or addictive drugs. Respondent did not request or require a controlled substance agreement for benzodiazepines, he did not review CURES reports at any time, nor did he make any effort to ensure that this patient was not taking other illicit substances or diverting medications.

71. Respondent's care and treatment of patient S.M. collectively constitutes repeated negligent acts in violation of section 2234(c) of the code as follows: Respondent's action of inappropriately prescribing long-term benzodiazepines to patient S.M., (who had a history of prior addiction and a complicated mental health history); Respondent's failure to counsel the patient about the risks of such benzodiazepine medications; Respondent's failure to closely monitor the use of controlled substances in this patient from 2010 through 2015, (which placed the patient at risk of overdose and misuse); Respondent's lack of awareness of toxicology report results in 2015 and 2016; Respondent's failure to thoroughly evaluate the patient's mental health

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conditions and coordinate with family members and other providers; and Respondent's creation of often illegible records and his failure to include any phone messages pertinent to this patient in the medical records.

EIGHTH CAUSE FOR DISCIPLINE
(Inadequate Record Keeping - Patient S.M.)

72. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2266 of the code in that his medical record keeping was inadequate. The circumstances are as follows:

73. Complainant re-alleges paragraphs 64-71 above and incorporates them by reference herein as though fully set forth.

74. Respondent's illegible entries in the medical record along with the fact that he did not record any telephone calls from patient S.M.'s family each constitute inadequate record keeping in violation of section 2266 of the code.

NINTH FOR DISCIPLINE
(Failing to Establish Written Protocols and Procedures for FNP)

75. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under sections 2234, 2234(b), and 2725 of the code and Title 16 CCR sections 1379 and 1474 in that he failed to establish written protocols and/or formularies for his Furnishing Nurse Practitioner who treated patient S.M. The circumstances are as follows:

76. Complainant re-alleges paragraphs 64-71 above and incorporates them by reference herein as though fully set forth.

77. On or about April 7, 2015, FNP[7] M.R. saw patient S.M. for a cataract surgery clearance for the patient's right eye. In addition, FNP M.R. authorized refills for #30 1 mg Ativan tablets and #100 100 mg Seroquel tablets. No written protocols and procedures including written formularies were in effect from Respondent at the time of this patient visit. Respondent's failure to establish written protocols and procedures including formularies with FNP M.R.

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[7] This Registered Nurse was a Furnishing Nurse Practitioner.

constitutes a violation of section 2725 of the code, is general unprofessional conduct and constitutes an extreme departure from the standard of care.

TENTH CAUSE FOR DISCIPLINE
(Failing to Establish and Enforce Written Protocols and Procedures for PA)

78. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under sections 2234, 2234(b), 3502, and 3502.1 of the code and Title 16 CCR sections 1399.540 and 1399.545, in that he failed to establish and enforce written protocols and/or formularies for his Physician Assistant who treated patients W.W., R.H., D.C. and D.W. which was grossly negligent. The circumstances are as follows:

79. In or about December, 2011, to October 11, 2012, Physician Assistant (P.A.) S.C. was employed by Respondent at 5145 Shasta Dam Road, Shasta Lake, CA (hereinafter referred to as the "Shasta Lake Office"). In or about July 1, 2012 through December 31, 2012, the Department of Health Care Services conducted a field audit of Dr. Budhram's medical practice and found that under that period of review that Dr. Budhram's supervision of P.A. S.C. was inadequate. On or about December 9, 2013, the Department of Health Care Services wrote a letter to both the Medical Board and the Physician Assistant Board indicating that their audit revealed that there was a lack of protocols pertaining to the PA's care of patients (including furnishing protocols), a lack of physician co-signature on the PA's charts, particularly on visits involving transmission of Schedule II drug orders, and a delegation of services agreement that was inconsistent with the clinical practice.

80. Though Dr. Budhram had a delegation of services agreement with P.A. S.C. , he did not have any written protocols or formularies for the PA's prescribing practices. In addition, P.A. S.C. had not taken a required prescribing course which is necessary if she was going to prescribe to patient's independently of having Dr. Budhram approve and co-sign each of the patient charts.

81. On or about August 7, 2012, P.A. S.C. undertook the care of patient W.W., a 52-year-old male who recently fell on a log and scratched his leg. The wound on his thigh was to be treated with antibiotics. He requested a dermatology referral for jock itch and had ongoing COPD, and essential tremor. P.A. S.C. renewed prescriptions for #90 Lorcet 650 mg-10 mgs,

#90, Depakote 500 mg; #60 Ativan 1 mg., #30 Trazodone Hydrochloride 50 mg, #90 Gabapentin 300 mgs, and Xopenex Inhaler 45 mcg/inh.

82. On or about August 21, 2012, P.A. S.C. again saw Patient W.W. for a requested increase in the patient's Lorcet. On or about September 19, 2012, P.A. S.C. saw patient W.W. with an attitude problem which may be due to medication, and a complaint of constipation.

83. On or about September 18, 2012, P.A. S.C. undertook the care of patient R.H., a 49 year -old male who was asking for nitroglycerin because of a concern that his heart stops. The record noted that the patient had been to cardiology about this concern previously but the patient did not recall the visit. This patient had a history of Paranoid Schizophrenia and was a poor historian. P.A. S.C.'s plan was to obtain old records from the cardiology visit to discuss with the patient. P.A. S.C. noted that prescriptions were refilled but did not note which drugs, as the patient was taking at least four different medications including #90 Tylenol with Codeine 300 mg-30 mg. On or about October 9, 2012, P.A. S.C. again saw patient R.H. to discuss heart issues and to get medication refills. This time all medications were refilled.

84. On or about September 10, 2012, P.A. S.C. undertook the care of patient D.C., a 47-year-old male, to discuss his medications, his chronic pain and to reduce the drug gabapentin due to bladder retention. D.C. was taking many medications including OxyContin Hydrochloride, 15 mg, and Methadone Hydrochloride 10 mg, both Schedule II controlled substances. P.A. S.C. discontinued the Trazadone prescription for D.C. and started the patient on Meloxicam 7.5 mg once a day and Sinequan 75 mg daily.

85. This patient was again seen by P.A. S.C. on or about September 27, 2012 to discuss worsening lower back, buttock, hip and right leg pain. In addition, the patient complained about body jerking at night with Doxipen (should be Doxepin) and urine retention. The patient related to P.A. S.C. that his urination symptoms were positional. The patient's medications are listed as: Lidoderm patch apply one patch q 12 hrs prn; Meloxicam 7.5 mg one q day; Oxycodone hydrochloride 15 mg one BID; Pamelor 50 mg one bid; docusate sodium 250 mg one bid; Xanaflex 4 mg one bid prn spasm; Claritin 10 mg one a day; Methadone hydrochloride 10 mg one tid; Norco 10/325 mg one QID; Cymbalta 30 mg one a day. P.A. S.C. instructed D.C. to remove

his Lidoderm patches, prescribed Lyrica 25mg bid for possible restless leg syndrome, stopped the patient's Neurotin and Doxepin and increased the Zanaflex without consultation with Respondent.

86. On or about September 6, 2012, P.A. S.C. undertook the care of patient D.W. a 47-year-old woman, for a well woman examination. P.A. S.C. performed a pelvic exam and found that the patient had vaginitis and vulvovaginitis, pelvic dyspareunia secondary to adhesions and endometriosis. P.A. S.C. prescribed Diflucan 150 mg tablet for the vaginitis and renewed the patient's prescription for Norco 325 mg.

ELEVENTH CAUSE FOR DISCIPLINE
(Gross Negligence – Inappropriate Opioid Prescribing/Failure to Closely Monitor Controlled Substances Use - Patient A)

87. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient A.[8] The circumstances are as follows:

88. On or about March 9, 2012, patient A, a 22-year-old male, died of an apparent accidental morphine overdose, complicated by a known seizure disorder, which developed after patient was taking opioids. At the time of his death, patient A was under the care and treatment of Respondent for chronic pain, involving the left knee, left hip, and back, as well as care and treatment for depression, anxiety, and angry outbursts. Respondent treated patient A from September 23, 2009 until his death.

89. Prior to being treated by Respondent, patient A took Tramadol, a non-narcotic, for his knee pain. However, Respondent was the physician who initiated patient A on opioid treatment. According to CURES data, and prescription records, Respondent prescribed approximately 120 Vicodin 5/500, to patient A, monthly from April 20, 2011 through March 2, 2012. Additionally, Respondent prescribed approximately 90 clonazepam (Klonopin), .5 mg., to patient A, monthly from April 20, 2011 through March 2, 2012. Respondent also prescribed Ultram (Tramadol) 50

[8] This alphabetical identifier is used to protect confidentiality and the patient's name will be disclosed in discovery.

mg. #180 (for pain), and Abilify[9] 30 mg. #30 (for depression), on April 20, 2011 to patient A. On June 11, 2011, Respondent again prescribed Ultram 50 mg #120 to patient A. On May 18, 2011, August 1, 2011 and October 2, 2011, Respondent again prescribed Abilify to patient A. On September 26, 2011, patient A received a prescription of 30 Tylenol with Codeine III from Respondent.

90. On or about March 27, 2011, patient A was resuscitated in the Emergency Department of Mercy Medical Center after stealing his mother's Fentanyl. When patient A awoke, he took a Fentanyl patch out of the roof of his mouth. This patient expressed ambivalent suicidal ideation in the Emergency Department, but was later assessed by a mental health practitioner who judged him not to be suicidal. The notes from this emergency room visit were cc'd to Respondent. On or about May 6, 2011, a toxicology screen ordered by Respondent of patient A revealed the presence of non-prescribed Fentanyl. Hydrocodone and Benzodiazepines were also present. Respondent wrote in his notes to discontinue pain medication, that patient denies, and that Respondent will give him one chance. Respondent continued prescribing opioid pain medication despite this red flag.

91. On or about July 7, 2011, patient A arrived by ambulance at the Emergency Department (ED) after a possible seizure. The ED impression is "altered mental status with questionable seizure-like activity" of unclear etiology. On or about July 9, 2011, a urine toxicology screen from Mercy Medical Center is positive for opiates and barbituates. Dilantin, an anti-convulsant, used to treat seizures, is not on the medication list. On or about August 1, 2011, Respondent has a follow-up visit with patient A and in addition to the standard prescriptions for Vicodin and Klonopin, Respondent prescribes Dilantin 100 3/d and Abilify 30 mg. #30. On or about August 3, 2011, Respondent reduced the dose of Dilantin for patient A, despite the patient's recent seizure. On or about August 9, 2011, patient A has a second seizure.

92. On or about October 12, 2011, Respondent diagnosed patient A with depression and with trouble sleeping. Respondent discontinued Abilify and instead prescribed Prozac 10 mg

[9] Abilify is an antidepressant and an antipsychotic which is classified as a dangerous drug pursuant to Bus. and Prof. Code section 4022.-

daily to patient A. Additionally, the standard Vicodin and Klonopin prescriptions were continued by Respondent. On October 17, 2011, Respondent completed a disability form for patient A, indicating an indefinite disability due to anxiety and depression starting back on April 1, 2011. Then, on or about February 27, 2012, there is another visit to the ED by patient A, for grand mal seizure disorder. At the time, the patient was taking Dilantin, Klonopin .5 tid, Prozac 10 mg. daily and Vicodin 5/500, 2 q 6 #120x3.

93. Respondent's care and treatment of patient A's pain was grossly negligent in the following respects:

a. Respondent failed to document a sufficient history and physical to justify starting and continuing this young man on opioid pain medication;

b. Respondent failed to document a clear assessment of the nature of patient A's pain and the impact it had on his function, as well as Respondent's failure to assess and document prior treatment strategies;

c. Respondent failed to establish a treatment plan for patient A with identifiable benchmarks;

d. Respondent failed to conduct an assessment of the patient's addiction risk, even though he was prescribing narcotic therapy for his chronic pain and he failed to make the diagnosis of substance use disorder after patient's A's two incidents of illegal use of Fentanyl;

e. Respondent failed to obtain a thorough history of the patient's substance abuse problem, and failed to consult and consider collateral sources and address the other red flags of addiction that arose from Mercy Hospital records, as well as the positive drug screen of May 5, 2011. Respondent failed to document a plan to prevent future aberrant drug behavior;

f. Respondent should not have prescribed Klonopin simultaneously with Ultram and Vicodin, and Respondent failed to explain why he was prescribing sedative medication in conjunction with chronic narcotic therapy. Each of these medications suppress the central nervous system. Respondent should not have combined Ultram and Vicodin to

patient A until each narcotic was tried as a separate agent;

g. Respondent should not have prescribed Abilify simultaneously with Vicodin and Ultram to a patient with a seizure disorder because Abilify and Vicodin interact and can increase a patient's risk of seizure. In addition, Ultram and Vicodin taken together can cause life threatening ventricular tachyarrhythmias;

h. After starting patient A on Vicodin, Ultram, Klonopin and Abilify, on April 20, 2011, Respondent learned on May 6, 2011 that patient A took non-prescribed Fentanyl, yet Respondent continued to prescribe Vicodin on May 6, 2011 and Ultram on June 11, 2011 which had a black box warning for addiction; and

i. On August 3, 2011, when patient A complained he was drowsy, Respondent reduced the patient's Dilantin medication, which led to a second seizure rather than reducing the combined medications of Vicodin, Klonopin, Ultram and/or Abilify.

TWELFTH CAUSE FOR DISCIPLINE
(Gross Negligence – Inappropriate Management of Psychiatric Conditions - patient A)

94. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient A. The circumstances are as follows:

95. Complainant re-alleges paragraphs 88 through 92.

96. Respondent failed to adequately manage patient A's mental health complainants including depression and anxiety. These failures constitute extreme departures from the standard of care in violation of section 2234(b) of the code as follows:

a. Respondent failed to clearly document patient A's depressive and anxiety symptoms with or without the use of a formal scale, as well as failing to document the presence or absence of hallucinations or delusions;

b. Respondent failed to monitor suicidal thoughts or actions of patient A after he prescribed Abilify and after he prescribed Prozac to this patient;

c. Respondent failed to clearly document the rationale for treating patient A's depression with Abilify rather than Prozac, and his failure to modify treatment

in light of the presence in patient A's system of non-prescribed Fentanyl which can affect suicidal action; and

d. Respondent failed to refer patient A for psychological counseling.

THIRTEENTH CAUSE FOR DISCIPLINE
(Gross Negligence – Inappropriate Opioid Prescribing/Failure to Closely Monitor Controlled Substances Use - Patient B)

97. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient B. The circumstances are as follows:

98. On or about August 30, 2012, patient B, a 52-year-old female, died of an apparent methadone overdose, which were prescribed by Respondent. At the time of her death, patient B was under the care and treatment of Respondent for chronic pain, suicide attempts, PTSD (Post-traumatic Stress Disorder), due to a history of domestic violence, bipolar disorder, anxiety, history of alcoholism in sustained remission, and COPD, (Chronic Obstructive Pulmonary Disease)

99. When patient B first came to Respondent's practice in January 2009, she was taking high-dose transdermal Fentanyl. Respondent reduced the patient's Fentanyl and transitioned treatment to methadone of 10 mg twice daily and Norco 10/325 four times daily. According to CURES data, and prescription records, the amount of methadone prescribed by Respondent to patient B increased to three times daily on or about May 29, 2009, was increased to four times daily on July 26, 2012, and was then increased to six tablets a day on August 27, 2012, just three days before patient B's death. According to CURES data, and prescription records, Respondent prescribed Norco 10/325, (hydrocodone), to patient B four times daily during 2009, 2011 and 2012, but reduced the amount of Norco in 2010 to two times daily.

100. With respect to prescribing benzodiazepine drugs to patient B, according to CURES data, and prescription records, Respondent prescribed 10 mg per day of temazepam (Restoril) covering 2009 through 2012. Additionally, commencing on or about November 18, 2011 Respondent prescribed clonazepam (Klonopin), 1 mg., three times a day (or 90 tablets monthly),

to patient B, but then switched to lorazepam (Ativan) 1 mg, three times daily, from December 5, 2011 to May 29, 2012. From May 29, 2012 through August 30, 2012, Respondent prescribed to patient B, clonazepam .5 mg, three times a day.

101. On or about April 29, 2010, a Pain Management Agreement was signed by patient B. On June 22, 2012, a toxicology screen of patient B was negative for opiates (methadone and hydrocodone), and on July 26, 2012 a toxicology screen was negative for hydrocodone. Respondent never documented a discussion regarding the inconsistent toxicology results, nor any discussion with patient B regarding the dangers of combining benzodiazepines with opioids.

102. Respondent's care and treatment of patient B's pain was grossly negligent in the following respects:

a. Respondent should not have prescribed temazepam, clonazepam and/or lorazepam in combination with Norco and methadone to patient B, and Respondent failed to advise and document the dangers of prescribing sedative medication in conjunction with chronic narcotic therapy to patient B.

FOURTEENTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts –patient B and patient S.M.)

103. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(c) of the code in that he was repeatedly negligent in his care and treatment of patients B and S.M.

104. Complainant re-alleges paragraphs 98 to 101 and paragraphs 65-71.

105. Respondent was negligent in his care of patient B when he failed to document any discussion about discrepant toxicology screening results on June 22, 2012 and July 26, 2012, with negative results for opiates and/or hydrocodone.

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FIFTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence – Inappropriate Management of Psychiatric Conditions - patient B)

106. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient B. The circumstances are as follows:

107. Complainant re-alleges paragraphs 98 through 101.

108. Respondent treated this patient who suffered from bipolar disorder, suicide attempts, PTSD (Post-traumatic Stress Disorder), due to a history of domestic violence, and anxiety, yet did not elicit a comprehensive history, nor administer psychological tests, nor used standardized anxiety scales to measure the patient's anxiety levels, nor sought a psychiatric consult.

109. Respondent failed to adequately manage patient B's mental health conditions, and such failures constitute extreme departures from the standard of care in violation of section 2234(b) of the code as follows:

a. Respondent failed to clearly document a thorough mental history and physical examination of patient B's mental health conditions;

b. Respondent failed to assess the suicide risk of patient B, either initially and/or at regular intervals;

c. Respondent failed to assess psychotic symptoms of patient B at regular intervals;

d. Respondent failed to use objective measures by which progress in mental health treatment could be measured;

e. Respondent failed to refer patient B for psychiatric evaluation and treatment;

f. Respondent should not have prescribed methadone with Seroquel and/or Trazodone without maintaining vigilance for QT prolongation;

g. Respondent should not have prescribed tamazepam with either clonazepam or lorazepam. Respondent then compounded his prescribing errors by failing to remember which medication he was prescribing and for what indication when interviewed by an HQIU Investigator; and

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h. Respondent's action of prescribing a cocktail of Norco, methadone, Seroquel, Trazodone and two different benzodiazepines to patient B increased her risk of death or severe injury even without her ultimate suicide.

SIXTEENTH CAUSE FOR DISCIPLINE
(Inadequate Record Keeping – Patients A and B)

110. Respondent Harold S. Budhram, M.D. is subject to disciplinary action under section 2266 of the code in that his medical record keeping was inadequate. The circumstances are as follows:

111. Complainant re-alleges paragraphs 88-96 and 98-105 above and incorporates them by reference herein as though fully set forth.

112. Respondent's failure to document the history and physical, the treatment plan, the assessment, and the substance abuse history of Patient A, as well as his failure to document the history and physical, treatment plan, and assessment of Patient B, constitutes inadequate record keeping in violation of section 2266 of the code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's License No. G 31973, issued to Respondent Harold S. Budhram, M.D.;

2. Revoking, suspending or denying approval of Respondent Harold S. Budhram, M.D.'s authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Harold S. Budhram, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED: April 18, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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